SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Filing at a Glance

Company: Medico Insurance Company

Product Name: AR Elec A18 DVH Product	SERFF Tr Num: MDIC-126077344	State: ArkansasLH
TOI: H10I Individual Health - Dental	SERFF Status: Closed	State Tr Num: 41868
Sub-TOI: H10I.000 Health - Dental	Co Tr Num: CR-AR-ELEC A18 DVH PRODUCT	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Cathy Richter	Disposition Date: 03/23/2009
	Date Submitted: 03/20/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: CR-AR-Elec A18 DVH Product	Status of Filing in Domicile: Authorized
Project Number: CR-AR-Elec A18 DVH Product	Date Approved in Domicile: 03/10/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 03/23/2009	Explanation for Other Group Market Type:
	State Status Changed: 03/23/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Filing of electronic versions of our previously approved forms associated with the A18 Dental, Vision and Hearing Policy (Approved April 21, 2008) by the Arkansas Department.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Cathy Richter, Assistant Compliance Analyst
1515 S. 75th Street
Omaha, NE 68124

cathyrichter@gomedico.com
(800) 695-5976 [Phone]
(402) 391-4858[FAX]

Filing Company Information

Medico Insurance Company
1515 S. 75th Street
Omaha, NE 68124
(800) 695-5976 ext. [Phone]

CoCode: 31119
Group Code: 364
Group Name: Medico
FEIN Number: 47-0122200

State of Domicile: Nebraska
Company Type: Life and Health
State ID Number:

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	Forms associated with previously approved policy MI-DVA18
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	$50.00	03/20/2009	26561914

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/23/2009	03/23/2009

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Disposition

Disposition Date: 03/23/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Policy and Schedule	Approved-Closed	Yes
Form	Replacement Notice	Approved-Closed	Yes

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Form Schedule

Lead Form Number: MIHAA18(AR)-E

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MI9F-1060-E	Other	Replacement Notice	Initial			MI9F-1060-E-09052008.pdf

MEDICO™ INSURANCE COMPANY
1515 South 75th Street • Omaha, Nebraska 68124

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Medico™ Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

_____
(Date)

Typing your name and selecting "Continue" shall constitute an electronic signature, which has the same force and effect as a signature affixed by hand.

_____
(Applicant’s Signature)

Continue Stop

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 03/23/2009

Comments:

Attachments:

AR-Certification.pdf

AR-Flesch Certificate MIC.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 03/23/2009

Comments:

Attachments:

MIHAA18(AR)-E-03092009.pdf

MIHAA18(AR)-EA-03092009.pdf

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 03/23/2009

Comments:

Attachment:

MI9F-4331-E-01142009.pdf

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 03/23/2009

Comments:

Attachment:

AR cover letter 03172009.pdf

Satisfied -Name: Policy and Schedule **Review Status:** Approved-Closed 03/23/2009

Comments:

The policy and outline are attached as reference material only. They were approved by your Department on April 21, 2008.

Attachments:

SERFF Tracking Number:	*MDIC-126077344*	*State:*	*Arkansas*
Filing Company:	*Medico Insurance Company*	*State Tracking Number:*	*41868*
Company Tracking Number:	*CR-AR-ELEC A18 DVH PRODUCT*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*AR Elec A18 DVH Product*		
Project Name/Number:	*CR-AR-Elec A18 DVH Product/CR-AR-Elec A18 DVH Product*		

MI-DVA18-04032008.pdf

A18 Schedule.pdf

ARKANSAS CERTIFICATION

Medico® Insurance Company hereby
Insurer

certifies that this filing complies with the requirements of Arkansas Insurance Rule and Regulation 19 as well as all other requirements of the Arkansas Insurance Department.

Signature

Desiree Buckley, VP & Director of Compliance
Officer's name and title

March 13, 2009
Date

FLESCH READABILITY CERTIFICATION

Form Number MI-DVA18-E has been Flesch tested.
The Flesch Readability Score was computed to be 45.7.

Form Number MI9F-4331-E has been Flesch tested.
The Flesch Readability Score was computed to be 40.2.

Form Number MI9F-1060-E has been Flesch tested.
The Flesch Readability Score was computed to be 40.3.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

MEDICO INSURANCE COMPANY

Desiree Buckley

Desiree Buckley
Vice President, Director of Compliance

MEDICO™ INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

www.gomedico.com
Toll-Free 1-800-228-6080

Application for Dental, Vision and Hearing Insurance

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part A: General Information – Please Print

Applicant Information

Name _____ _____ _____ _____
First MI Last Date of Birth (Mo./Day/Yr.) Age Sex

Address _____
Street Address City State Zip

Social Security # _____

Phone # _____ E-mail Address _____

Part B: Medical Information

1. (a) Do you currently wear dentures? ☐ Yes ☐ No

   (b) Have you been advised to have any dental work which has not been completed? ☐ Yes ☐ No

   If "Yes," provide details:

   _____

2. (a) Do you currently wear eyeglasses or contact lenses? ☐ Yes ☐ No

   (b) Have you received advice or treatment within the past nine months for correction of a vision problem? ☐ Yes ☐ No

   If "Yes," provide details:

   _____

3. (a) Do you currently wear a hearing aid? ☐ Yes ☐ No

   (b) Have you been treated for hearing loss within the past nine months? ☐ Yes ☐ No

   (c) Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency? ☐ Yes ☐ No

Part C: Applicant Information

1. (a) Do you have any dental, vision or hearing insurance currently in force? ☐ Yes ☐ No

   (b) Is the insurance applied for intended to replace any existing insurance with this or any other company? ☐ Yes ☐ No

   If "Yes," provide type of contract or policy number, and name of company:

   _____

   (c) If replacement is involved, have you received a replacement form (in states where required by law)? ☐ Yes ☐ No

Part D: Benefit Option

Check the Benefit you prefer:

Policy Year Maximum: ☐ $1,000 ☐ $1,500

Part E: Payment Options

☐ Household Discount

Provide the following information:

Make all checks payable to: Medico™ Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment: Frequency of Payment:

☐ Automatic Bank Withdrawal ☐ Monthly ☐ Bi-Monthly ☐ Quarterly

☐ Direct Bill ☐ Bi-Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Amount Received with Application $_____ Renewal Premium $_____

Please Note – If this application is being submitted electronically, the system will automatically indicate "None" for the "Amount Received with Application." Your first premium payment will be withdrawn from your bank account as soon as your application is approved by the Home Office of Medico™ Insurance Company.

Requested Effective Date of Policy (optional) _____
(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Part F: Application Agreement

I hereby apply to Medico™ Insurance Company for a **Dental, Vision and Hearing Insurance Policy** to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, or prescription/pharmaceutical database that has any record or knowledge of me or my health, to give to Medico™ Insurance Company any such information. I understand that a photocopy of this authorization shall be as valid as the original and that this authorization shall remain valid for 24 months unless revoked by me in writing to the Home Office of Medico™ Insurance Company.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following regarding eligibility for Medicare and "A Guide to Health Insurance for People With Medicare":

☐ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at gomedico.com/products.

☐ 2. I have received a hard copy of the Medicare Buyers Guide.

☐ 3. I am not eligible for Medicare.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind your policy.

I am applying for this Dental, Vision and Hearing insurance.

Typing your name and selecting "Continue" shall constitute an electronic signature, which has the same force and effect as a signature affixed by hand.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Signature _____ Date _____

Continue **Stop**

MEDICO™ INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

www.gomedico.com
Toll-Free 1-800-228-6080

Application for Dental, Vision and Hearing Insurance

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part A: General Information – Please Print

Applicant Information

Name _____ _____ _____ _____
First MI Last Date of Birth (Mo./Day/Yr.) Age Sex

Address _____
Street Address City State Zip

Social Security # _____

Phone # _____ E-mail Address _____

Part B: Medical Information

1. (a) Do you currently wear dentures? ☐ Yes ☐ No

   (b) Have you been advised to have any dental work which has not been completed? ☐ Yes ☐ No

   If "Yes," provide details:

   _____

2. (a) Do you currently wear eyeglasses or contact lenses? ☐ Yes ☐ No

   (b) Have you received advice or treatment within the past nine months for correction of a vision problem? ☐ Yes ☐ No

   If "Yes," provide details:

   _____

3. (a) Do you currently wear a hearing aid? ☐ Yes ☐ No

   (b) Have you been treated for hearing loss within the past nine months? ☐ Yes ☐ No

   (c) Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency? ☐ Yes ☐ No

Part C: Applicant Information

1. (a) Do you have any dental, vision or hearing insurance currently in force? ☐ Yes ☐ No

   (b) Is the insurance applied for intended to replace any existing insurance with this or any other company? ☐ Yes ☐ No

   If "Yes," provide type of contract or policy number, and name of company:

   _____

   (c) If replacement is involved, have you received a replacement form (in states where required by law)? ☐ Yes ☐ No

Part D: Benefit Option

Check the Benefit you prefer:

Policy Year Maximum: ☐ $1,000 ☐ $1,500

Part E: Payment Options

☐ Household Discount ☐ Association Discount Association Name _____

Member Identification Number _____

Provide the following information:

Make all checks payable to: Medico™ Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment: Frequency of Payment:

☐ Automatic Bank Withdrawal ☐ Monthly ☐ Bi-Monthly ☐ Quarterly

☐ Direct Bill ☐ Bi-Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Amount Received with Application $_____ Renewal Premium $_____

Please Note – If this application is being submitted electronically, the system will automatically indicate "None" for the "Amount Received with Application." Your first premium payment will be withdrawn from your bank account as soon as your application is approved by the Home Office of Medico™ Insurance Company.

Requested Effective Date of Policy (optional) _____
(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Part F: Application Agreement

I hereby apply to Medico™ Insurance Company for a **Dental, Vision and Hearing Insurance Policy** to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, or prescription/pharmaceutical database that has any record or knowledge of me or my health, to give to Medico™ Insurance Company any such information. I understand that a photocopy of this authorization shall be as valid as the original and that this authorization shall remain valid for 24 months unless revoked by me in writing to the Home Office of Medico™ Insurance Company.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following regarding eligibility for Medicare and "A Guide to Health Insurance for People With Medicare":

☐ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at gomedico.com/products.

☐ 2. I have received a hard copy of the Medicare Buyers Guide.

☐ 3. I am not eligible for Medicare.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind your policy.

I am applying for this Dental, Vision and Hearing insurance.

Typing your name and selecting "Continue" shall constitute an electronic signature, which has the same force and effect as a signature affixed by hand.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Signature _____ Date _____

Continue **Stop**

MEDICO™ INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

gomedico.com
Toll-Free 1-800-228-6080

LIMITED BENEFIT POLICY
DENTAL, VISION AND HEARING COVERAGE

RETAIN THIS OUTLINE FOR YOUR RECORDS
THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract. Only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you **READ YOUR POLICY CAREFULLY**.

Limited Benefit Coverage: Policies of this type are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

BENEFITS PROVIDED BY THE POLICY

Policy Year Maximum Benefit: The maximum benefit we will pay during any one Policy Year. You may choose from:

☐ $1,000 ☐ $1,500

Policy Year Deductible: You are responsible for the first $100 of Covered Expenses during each Policy Year.

After satisfaction of the $100 Policy Year Deductible, the policy will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit based on the Policy Year:

60% – First Policy Year
70% – Second Policy Year
80% – Third Policy Year and thereafter

Covered Expenses, subject to the limitations described in the Exceptions and Limitations Section, are:

(1) Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

(2) Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one Policy Year.

(3) Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

After the policy has been in force three months, the policy will pay 100% of the cost of one dental cleaning up to a maximum benefit of $50 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

Reasonable and Customary Charges are the normal and prevailing charges, fees or expenses for the service rendered or for the material furnished in the geographic area where rendered or furnished.

EXCEPTIONS AND LIMITATIONS

Benefits will not be payable for the following items and/or services **during the first six months following the Policy Date:**

(1) Root canals; or

(2) Existing eyeglasses or contact lenses (including the renewal or changing of prescriptions).

Benefits will not be payable for the following items and/or services **during the first Policy Year:**

(1) Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions or fluoride treatments; or

(2) Existing hearing aids.

Benefits will not be paid under this policy for: (1) any loss resulting from war, declared or undeclared; (2) any intentionally self-inflicted Injury; (3) any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation; (4) any expense for which payment is provided under Medicare; (5) any services that are not recommended by a Physician, as defined by the policy; (6) any Experimental or Investigational procedure or treatment; (7) orthodontic treatment; (8) any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state; (9) expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts); (10) charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; (11) prescription drugs; (12) charges in excess of Reasonable and Customary Charges; (13) treatment or diagnosis received while outside the territorial limits of the United States; (14) services for which you are not liable or for which no charge normally is made in the absence of insurance; and (15) loss that occurs while the policy is not in force.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR DENTAL, VISION AND HEARING NEEDS.

RENEWABILITY AND PREMIUM CHANGES

Renewability – Guaranteed Renewable – This means you have the right, subject to the terms of your policy, to continue the policy as long as you pay your premiums before the end of the grace period.

Terms Under Which We May Change Premiums – We can change premiums only if we do the same to all policies of this form issued to persons of your class in your state, and we notify you in advance of the due date. "Class" means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under the policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PREMIUMS

Automatic Bank Withdrawal:

Monthly	Bi-Monthly	Quarterly

Direct Bill:

Bi-Monthly	Quarterly	Semi-Annually	Annually

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay your premium. Your policy stays in force during your grace period.

Continue Stop

March 17, 2009

MEDICO INSURANCE COMPANY
NAIC # 31119

Commissioner Jay Bradford
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Individual Dental, Vision and Hearing Policy

Enclosed Material:

MI9F-4331-E – Outline of Coverage
MIHAA18(AR)-E – Application
MIHAA18(AR)-EA - Application
MI9F-1060-E – Replacement Notice
Filing Forms

Enclosed for Reference:

MI-DVA18 – Policy (previously approved)

Enclosed, you will find a copy of an Individual Dental, Vision and Hearing Policy that was previously approved by your Department on April 21, 2008. Also enclosed are accompanying forms for your approval. These new forms will not replace any forms currently on file with your Department. They are intended to be used by our agents and be filled in and submitted electronically.

MI-DVA18 is a limited benefit policy. Outline MI9F-4331-E differs from Outline MI9F-4331 (approved by your department on April 21, 2008) only in the Premiums section and the form number and version date.

Replacement notice MI9F-1060-E is essentially the same as MI9F-1060 (approved by your Department on April 21, 2080) except where the applicant signs his/her name.

The two applications enclosed are modeled after MIHAA18(AR) (approved by your Department on April 21, 2008) except we have removed all reference to co-applicant. Where the applicant needs to sign has been modified and so has Part E: Payment Options. MIHAA18(AR)-E and MIHAA18(AR)-EA differ from each other in that MIHAA18(AR)-EA makes reference to an Association under Part E.

We intend to offer the policy through our producers to eligible individuals who are ages 18 through 84. A sample schedule is attached to the policy for your reference. Any information contained in the brackets will vary to fit each policyholder. The outline of coverage will be furnished to each applicant as required by state law. The enclosed Applications have been enclosed for your approval.

MI9F-1060-E will be used when required by state law. I would like to request approval of this form so it can be used with any similar products the company may have approved in the future.

MEDICO®
INSURANCE COMPANY

At this time, I am not providing any hard copies of the electronic process itself, per a conversation our research analyst had with Rosalyn at the Department. Basically, an agent accesses a link to the Electronic Application Process. The process takes the agent and/or applicant through a series of steps, giving them a choice of continuing or stopping the application process. After the application process is completed, the agent/applicant will be able to print and/or save all the documents for the applicant's records, and the applicant will receive an email (if he/she provides us with an e-mail address) acknowledging the transaction. Instructions are given to either print or save the record at the end of the application process.

I thank you in advance for your prompt review and approval of this submission. If you have any questions, please feel free to contact me.

Sincerely,

Cathy Richter

Cathy Richter
Compliance Assistant II
1-800-695-5976 Ext. 236
Fax (402) 391-4858
cathyrichter@gomedico.com

MEDICO™
INSURANCE COMPANY
A STOCK INSURANCE COMPANY
1515 South 75th Street • Omaha, Nebraska 68124 • 1-800-228-6080

DENTAL, VISION AND HEARING EXPENSE POLICY

CAUTION: **The issuance of this policy is based upon your responses to the questions on your application. A copy of your application is attached to the policy. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.**

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your attached application), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life as long as the premium is paid within the allowable time. We do have the right to change your premium as stated below.

Premium Change: We can change your premium only if we do the same to all policies of this form issued to persons of your class. "Class" means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

NOTICE TO BUYER: **This policy may not cover all of the costs incurred by you during the period of coverage. You are advised to carefully review all policy limitations.**

LIMITED BENEFIT INSURANCE POLICY FOR DENTAL, VISION AND HEARING EXPENSES

ALPHABETICAL GUIDE TO YOUR POLICY

PART C EXCEPTIONS AND LIMITATIONS

We will NOT pay benefits for the following items and/or services during the first six months following the Policy Date:

1. root canals; or
2. existing eyeglasses or contact lenses (including the renewal or changing of prescriptions).

We will NOT pay benefits for the following items and/or services during the first Policy Year:

1. bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions or fluoride treatments; or
2. existing hearing aids.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared;
2. any intentionally self-inflicted Injury;
3. any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation;
4. any expense for which payment is provided under Medicare;
5. any services that are not recommended by a Physician, as defined by this policy;
6. any Experimental or Investigational procedure or treatment;
7. orthodontic treatment;
8. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state;
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts);
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures;
11. prescription drugs;
12. charges in excess of Reasonable and Customary Charges;
13. treatment or diagnosis received while outside the territorial limits of the United States;
14. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
15. loss that occurs while this policy is not in force.

PART D POLICY YEAR DEDUCTIBLE AND MAXIMUM BENEFIT

There is a Policy Year Deductible which is shown in the Schedule. After the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit shown in the Schedule.

PART E DEFINITIONS

Audiologist: A person duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Covered Expenses: Expenses for necessary medical and dental services or supplies prescribed by a Physician. They may not be more than the Reasonable and Customary Charges for such services or supplies. Covered Expenses for services or supplies will be deemed to be incurred on the date or dates such services or supplies are received by you. Covered Expenses must be incurred while this policy is in force.

Dentist: A person duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Experimental or Investigational: The use of a treatment (drugs, devices or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; that is, pre-market approval has not been granted (devices only);
2. benefits to at least one-third of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Immediate Family: Your spouse, parent, child, brother or sister, or any person living with you.

Injury: A bodily Injury caused directly by an accident, independent of sickness, disease, bodily infirmity or any other cause, occurring on or after the Policy Date and while coverage is in force. See the Exceptions and Limitations Section for Injuries not covered by this policy.

Medically Necessary: A service or care:

1. required for the treatment or management of a medical symptom or condition;
2. which is the most efficient and economical care or service which can be safely provided in keeping with current medical practices;
3. not administered solely for the convenience of an insured person or any provider; and
4. which is prescribed by a Physician.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Ophthalmologist: A Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Optometrist: A Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license, other than a member of the insured person's Immediate Family. Physician includes a licensed Dentist, Optometrist, Ophthalmologist, or Audiologist.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy's premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Policy Year: The year beginning on the Policy Date and on each following policy anniversary of the Policy Date.

Policy Year Deductible: The dollar amount for which you are responsible during each Policy Year. The amount of the Policy Year Deductible is shown in the Schedule.

Policy Year Maximum Benefit: The maximum benefit we will pay during any Policy Year. This amount is shown in the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Reasonable and Customary Charge: The normal and prevailing charge, fee or expense for the service rendered or for the material furnished in the geographic area where rendered or furnished.

Schedule: Is attached to and is a part of this policy.

We, Us or Our: Medico™ Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BENEFITS

After the Policy Year Deductible is satisfied, the policy pays the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% - First Policy Year;
2. 70% - Second Policy Year; and
3. 80% - Third Policy Year and thereafter.

Covered Expenses, subject to the Exceptions and Limitations, are:

1. Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.
2. Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one Policy Year.
3. Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

After the policy has been in force three months, the policy will pay 100% of the cost of one dental cleaning up to a maximum benefit of $50 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

PART G TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death. In the event of your death, we will promptly return the unearned portion of any premium paid beyond the date of death.

Except in the case of your death, if the termination date occurs within a period for which we have accepted a premium, or if we accept a premium after such date, this policy will continue in effect until the end of the period for which premiums have been accepted. This does not apply where the acceptance of premium was a result of misstatement of age by you. In that case, the Misstatement of Age Provision controls.

PART H HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our Producers.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART I PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to you. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to $1,000.00 ($5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

Claim Review and Appeal Procedure: In the event of any claim denial with which you do not agree, you have the right to submit a written request to us at our Home Office asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

PART J OTHER IMPORTANT PROVISIONS

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit On Certain Defenses: For a policy or certificate that has been in force for less than six months, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that is material to the acceptance of coverage.

For a policy or certificate that has been in force for at least six months, but less than two years, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that:

1. is material to the acceptance for coverage; and
2. pertains to the condition for which benefits are sought.

After a policy or certificate has been in force for two years, it is not contestable upon grounds of misrepresentation alone. The policy may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed, unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to the policy. The premium we accept to reinstate this policy will be used for a period for which premiums had not been paid. We must receive all back premiums for the policy to be reinstated.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Misstatement Of Age: If your age has been misstated, a premium adjustment will be made so that we receive the premiums that would have been due at the correct age.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Other Insurance With Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

Insurance With Other Insurers (Expense-Incurred Benefits): If there is other valid coverage, not with us, providing benefits for the same loss on a provision-of-service basis or on an expense-incurred basis and of which we have not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense-incurred coverage of this policy shall be for the proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all the other valid coverages for the same loss of which we have notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision-of-service basis, the "like amount" of the other coverage shall be taken as the amount which the services rendered would have cost in the absence of the coverage.

Insurance With Other Insurers (Other Benefits): If there is other valid coverage, not with us, providing benefits for the same loss on other than an expense-incurred basis and of which we have not been given written notice prior to the occurrence or commencement of loss, the only liability for the benefits under this policy shall be for the proportion of the indemnities otherwise provided under this policy for the loss as the like indemnities of which we have notice, including the indemnities under this policy, bear to the total amount of all like indemnities for the loss, and for the return of the portion of the premiums paid as shall exceed the pro rata portion for the amount thus determined.

Term Of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our President and Secretary sign this policy in our behalf.

President

Secretary

Countersigned By_____
Licensed Resident Producer

MEDICO INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NEBRASKA 68124

S C H E D U L E

POLICY NO. - [0000000] POLICY TYPE – A18

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

POLICY DATE ..... [11/01/05]
FIRST RENEWAL DATE ..... [11/01/06]
TOTAL FIRST PREMIUM ..... $ [XXXX.XX]
AGE AT ISSUE ..... [62]

--- POLICY PREMIUMS---
[MODE] ……... $ [XXX.XX]

---- ANNUAL ----

POLICY YEAR DEDUCTIBLE ……$100.00

POLICY YEAR MAXIMUM BENEFIT ..…….. $ [1,500.00]